New York City Comptroller
Scott M. Stringer

1 Centre Str
New York, NY 10(

Form Version: NYC-COMPT-BLA-PI1·

Personal Injury Claim Form

Electronically filed claims must be filed within 90 days of the occurrence using the Office of the NYC Comptroller's website. If the claim is not resolved within one (1) year and 90 days of the occurrence, you must start a separate legal action in a court of law before the expiration of this time period to preserve your rights.

ı filing: ◯ On behalf of myself.

◯ On behalf of someone else. If on someone else's behalf, please provide the following information.

Name:	
Name:	
tionship to claimant:	

mant Information

t Name:	Phillips
t Name:	Paul
dress:	[redacted]
ress 2:	
r:	[redacted]
te:	[redacted]
Code:	[redacted]
ıntry:	USA
e of Birth:	[redacted] Format: MM/DD/YYYY
Sec. #	[redacted]
N: dicare #)	[redacted]
e of Death:	Format: MM/DD/YYYY
ne:	[redacted]
ail Address	[redacted]
ype Email ress:	[redacted]
ıpation:	disabled

Employee? ◯ Yes ◉ No ◯ NA

der ◉ Male ◯ Female ◯ Other

◉ Attorney is filing.

Attorney Information (If claimant is represented by attorne

Firm or Last Name:	Wasserman, Steven
Firm or First Name:	The Legal Aid Society
Address:	199 Water Street
Address 2:	
City:	New York
State:	NEW YORK
Zip Code:	10038
Tax ID:	[redacted]
Phone #:	(212) 577-3387
*Email Address:	swasserman@legal-aid.org
*Retype Email Address:	swasserman@legal-aid.org

The time and place where the claim arose

*Date of Incident:	07/04/2020 Format: MM/DD/YYYY
Time of Incident:	12:00 AM Format: HH:MM AM/PM
*Location of Incident:	Rikers Island C-95 AMKC
Address:	18-18 Hazen St.
Address 2:	
City:	E. Elmhurst NYC
*State:	NEW YORK
Borough:	QUEENS

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Manner in which claim arose:

Claimant was detained by NYPD and NYCDOC for 3 or 4 days, based on a 32-year-old outstanding NY County warrant which proved to be non-existent.

Claimant was released after the Bronx District Attorney determined that there was no basis for his detention.

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items of nage or injuries ned are lude dollar unts):

In addition to the loss of 3 or 4 days' liberty, Claimant, who suffers from bipolar disorder, was unjustifiably deprive proper medication, and suffered ongoing psychological damage.

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lical Information

Treatment Date: Format: MM/DD/YYYY
pital/Name:
ress:
ress 2:
e:
Code:
Treated in rgency Room: Format: MM/DD/YYYY
claimant taken to hospital by mbulance? ◯ Yes ◯ No ◯ NA

oloyment Information (If claiming lost wages)

loyer's Name:
ress
ress 2:
e:
Code:
k Days Lost:
unt Earned kly:

ating Physician Information

Name:
Name:
ress:
ress 2:
e:
Code:

Witness 1 Information

Last Name:
First Name:
Address
Address 2:
City:
State:
Zip Code: Phone:

Witness 2 Information

Last Name:
First Name:
Address
Address 2:
City:
State:
Zip Code: Phone:

Witness 3 Information

Last Name:
First Name:
Address
Address 2:
City:
State:
Zip Code: Phone:

Witness 4 Information

Last Name:
First Name:
Address
Address 2:
City:
State:
Zip Code: Phone:

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Complete if claim involves a NYC vehicle

ner of vehicle claimant was traveling in

Name:	
Name:	
ress	
ress 2:	
e:	
Code:	

Non-City vehicle driver

Last Name:	
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

irance Information

rance Company ne:	
ress	
ress 2:	
e:	
Code:	
cy #:	
ne #:	

Non-City vehicle information

Make, Model, Year of Vehicle:	
Plate #:	
VIN #:	

City vehicle information

Plate #:	
City Driver Last Name:	
City Driver First Name:	

cription of mant:

- ○ Driver
- ○ Passenger
- ○ Pedestrian
- ○ Bicyclist
- ○ Motorcyclist
- ○ Other

l Amount med: $100,000.00 *Format: Do not include "$" or ",".*

Total Amount Claimed *can only be entered once the following ired fields are entered:*

mant Last Name
mant First Name
mant Address,City,State,Zip Code, and Country
mant Email or Attorney Email
e of Incident
ation of Incident (including State)
ner in which claim arose

certify that all information contained in this notice is true and correct to the best of my knowledge and belief. I understand that the willfu